FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032839

Facility Name: GLENWOOD HEALTHCARE & REHAB

Address: 19330 S. COTTAGE GROVE AVE (Number) GLENWOOD (City) 60425 (Zip Code)

County: COOK

Telephone Number: (847)674-4700 **Fax #** (847)674-4733

IDPA ID Number: 36-3532094

Date of Initial License for Current Owners: 09/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) BRADLEY ALTER

(Title) SECRETARY

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	92	Skilled (SNF)	92	33,672	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,672	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	184	TOTALS	184	67,344	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,187	4,187	8
9	SNF/PED					9
10	ICF	31,637	3,105	1,913	36,655	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,637	3,105	6,100	40,842	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.65%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 09/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 4,187

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,962	6,886	6,720	223,568		223,568		223,568			1
2	Food Purchase		211,606		211,606		211,606	(417)	211,189			2
3	Housekeeping	153,570	43,574		197,144		197,144	125	197,269			3
4	Laundry	99,849	16,869	1,750	118,468		118,468		118,468			4
5	Heat and Other Utilities			118,335	118,335		118,335		118,335			5
6	Maintenance	50,172	22,111	14,227	86,510		86,510	70	86,580			6
7	Other (specify):*			6,956	6,956		6,956		6,956			7
8	TOTAL General Services	513,553	301,046	147,988	962,587		962,587	(222)	962,365			8
	B. Health Care and Programs											
9	Medical Director			17,200	17,200		17,200		17,200			9
10	Nursing and Medical Records	1,423,044	123,041	57,975	1,604,060		1,604,060	21,378	1,625,438			10
10a	Therapy	30,861	1,091	700	32,652		32,652		32,652			10a
11	Activities	129,987	2,292		132,279		132,279		132,279			11
12	Social Services	41,246		3,180	44,426		44,426		44,426			12
13	Nurse Aide Training											13
14	Program Transportation			688	688		688		688			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,625,138	126,424	79,743	1,831,305		1,831,305	21,378	1,852,683			16
	C. General Administration											
17	Administrative	130,307		61,440	191,747		191,747	(3,045)	188,702			17
18	Directors Fees											18
19	Professional Services			93,097	93,097		93,097	(40,809)	52,288			19
20	Dues, Fees, Subscriptions & Promotions			39,503	39,503		39,503	(18,714)	20,789			20
21	Clerical & General Office Expenses	113,938	18,867	199,038	331,843		331,843	(56,370)	275,473			21
22	Employee Benefits & Payroll Taxes			453,798	453,798		453,798	28,117	481,915			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,162	3,162		3,162	10,578	13,740			24
25	Other Admin. Staff Transportation			2,677	2,677		2,677	13,490	16,167			25
26	Insurance-Prop.Liab.Malpractice			151,061	151,061		151,061	3,877	154,938			26
27	Other (specify):* MARKETING	50,614			50,614		50,614	(50,614)				27
28	TOTAL General Administration	294,859	18,867	1,003,776	1,317,502		1,317,502	(113,490)	1,204,012			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,433,550	446,337	1,231,507	4,111,394		4,111,394	(92,334)	4,019,060			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: GLENWOOD HEALTHCARE & REHAB #0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,720	
	REPAIRS & MAINTENANCE		0	
			0	6,720
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,750	
			0	1,750
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		30,628	
	ELECTRICITY		57,228	
	WATER		30,479	
	CABLE TV - LOBBY		0	
			0	118,335
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		4,438	
	PAINTING & DECORATING		46	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,573	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,425	
	FIRE SERVICE		745	
			0	
			0	
			0	14,227
7	**OTHER**			
	SCAVENGER		6,956	
	SECURITY SERVICE		0	6,956
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	17,200	17,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	54,843	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		319	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,598	
	PHARMACY CONSULTANT	XVIII B 39-2	1,215	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	57,975
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		245	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	455	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	700
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,180	
			0	3,180
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB **#0032839** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		688	688
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	61,440	61,440
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	8,094	
	ADMINISTRATIVE CONSULTANTS	XIX C	44,280	
	PROFESSIONAL FEES	XIX C	40,723	
			0	93,097
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	6,756	
	EMPLOYEE WANT ADS	XIX F	17,768	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	0	
	LICENSES & PERMITS	XIX F	2,973	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	11,756	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	250	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	39,503
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		3,322	
	OUTSIDE CLERICAL SERVICES		175,221	
	PENALTIES / OVERDRAFT CHARGES	VI 18	18,065	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		16	
	TELEPHONE		0	
	MESSENGER SERVICE		2,414	
			0	199,038

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	182,759	
	UNEMPLOYMENT COMPENSATION	XIX D	44,245	
	WORKERS COMPENSATION INSURANCI	XIX D	114,355	
	HOSPITALIZATION INSURANCE	XIX D	99,973	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,252	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	11,214	
	CHICAGO HEAD TAX	XIX D	0	453,798
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	800	
	TRAVEL	XIX G	2,362	
			0	
			0	3,162
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,677	2,677
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		151,061	151,061
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,231,507

GLENWOOD HEALTHCARE & REHAB
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	211,606	PATIENT MEALS	122526
LESS SALES TAX	(417)	ADD EMPLOYEE MEALS	0
NET FOOD	211,189	TOTAL MEALS/YEAR	122526
TOTAL PATIENT CENSUS	40,842	NET FOOD	211189
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	122526
TOTAL PATIENT MEALS	122526	COST PER MEAL	1.72
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB #0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			47,907	47,907		47,907	189,716	237,623			30
31	Amortization of Pre-Op. & Org.							24,533	24,533			31
32	Interest			20,313	20,313		20,313	477,503	497,816			32
33	Real Estate Taxes			279,496	279,496		279,496		279,496			33
34	Rent-Facility & Grounds			536,120	536,120		536,120	(528,043)	8,077			34
35	Rent-Equipment & Vehicles			13,189	13,189		13,189	603	13,792			35
36	Other (specify):*											36
37	**TOTAL Ownership**			897,025	897,025		897,025	164,312	1,061,337			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		83,942	316,130	400,072		400,072		400,072			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			101,016	101,016		101,016		101,016			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		83,942	417,146	501,088		501,088		501,088			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,433,550	530,279	2,545,678	5,509,507		5,509,507	71,978	5,581,485			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	21,671	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(417)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(18,065)	21		18
19	Entertainment		20		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(6,756)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,756)	20		28
29	Other-Attach Schedule MARKETING	(50,614)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (66,187)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	138,165		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 138,165		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 71,978		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GLENWOOD HEALTHCARE & REHAB

ID# 0032839

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(417)	0	0	0	0	0	0	0	0	0	0	(417)	2
3	Housekeeping	0	0	125	0	0	0	0	0	0	0	0	125	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	70	0	0	0	0	0	0	0	0	70	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(417)	0	195	0	0	0	0	0	0	0	0	(222)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	21,378	0	0	0	0	0	0	0	0	21,378	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	21,378	0	0	0	0	0	0	0	0	21,378	16
	C. General Administration													
17	Administrative	0	(61,440)	58,395	0	0	0	0	0	0	0	0	(3,045)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(44,280)	3,471	0	0	0	0	0	0	0	0	(40,809)	19
20	Fees, Subscriptions & Promotions	(18,762)	0	48	0	0	0	0	0	0	0	0	(18,714)	20
21	Clerical & General Office Expenses	(18,065)	(172,388)	134,083	0	0	0	0	0	0	0	0	(56,370)	21
22	Employee Benefits & Payroll Taxes	0	0	28,117	0	0	0	0	0	0	0	0	28,117	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	10,578	0	0	0	0	0	0	0	0	10,578	24
25	Other Admin. Staff Transportation	0	0	13,490	0	0	0	0	0	0	0	0	13,490	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,877	0	0	0	0	0	0	0	0	3,877	26
27	Other (specify):*	(50,614)	0	0	0	0	0	0	0	0	0	0	(50,614)	27
28	**TOTAL General Administration**	(87,441)	(278,108)	252,059	0	0	0	0	0	0	0	0	(113,490)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(87,858)	(278,108)	273,632	0	0	0	0	0	0	0	0	(92,334)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	21,671	164,991	3,054	0	0	0	0	0	0	0	0	189,716	30
31	Amortization of Pre-Op. & Org.	0	24,533	0	0	0	0	0	0	0	0	0	24,533	31
32	Interest	0	477,503	0	0	0	0	0	0	0	0	0	477,503	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(536,120)	8,077	0	0	0	0	0	0	0	0	(528,043)	34
35	Rent-Equipment & Vehicles	0	0	603	0	0	0	0	0	0	0	0	603	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	21,671	130,907	11,734	0	0	0	0	0	0	0	0	164,312	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(66,187)	(147,201)	285,366	0	0	0	0	0	0	0	0	71,978	45

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRADLEY ALTER	22.83	SEE ATTACHED SCHEDULE		CERTIFIED HEALTI	SKOKIE	BKKPG/MGMT
RITA L. GELLER	38.04			MGMT		
JOSEPH C. CHOW	39.13					
				GLENWOOD	SKOKIE	REAL ESTATE
				TERRACE LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 61,440	CERTIFIED HEALTH MGMT		$	$ (61,440)	1
2	V	21	BOOKKEEPING	175,221				(175,221)	2
3	V	19	ADMIN CONSULTING FEES	44,280				(44,280)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V	34	RENT	536,120	GLENWOOD TERRACE LLC			(536,120)	8
9	V	30	DEPRECIATION		" " "		164,991	164,991	9
10	V	31	AMORTIZATION		" " "		24,533	24,533	10
11	V	32	INTEREST		" " "		477,503	477,503	11
12	V	21	OFFICE EXP		" " "		2,833	2,833	12
13	V								13
14	Total			$ 817,061			$ 669,860	$ * (147,201)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 125	$ 125	15
16	V	5	ELECTRIC & GAS		" " "		0		16
17	V	6	MAINTENANCE		" " "		70	70	17
18	V	10	NURSING/MEDICAL RECORDS		" " "		21,378	21,378	18
19	V	17	ADMIN SALARIES		" " "		58,395	58,395	19
20	V	19	PROFESSIONAL FEES		" " "		3,471	3,471	20
21	V	20	FEE, SUBSCRIPTIONS		" " "		48	48	21
22	V	21	OFFICE EXP.		" " "		134,083	134,083	22
23	V	22	EMPLOYEE BENEFITS		" " "		28,117	28,117	23
24	V	24	TRAVEL/SEMINAR		" " "		10,578	10,578	24
25	V	25	TRANSPORTATION		" " "		13,490	13,490	25
26	V	26	INSURANCE		" " "		3,877	3,877	26
27	V	30	DEPRECIATION		" " "		3,054	3,054	27
28	V	32	INTEREST		" " "		0		28
29	V	34	OFFICE RENT		" " "		8,077	8,077	29
30	V	35	EQUIPMENT RENTAL		" " "		603	603	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 285,366	$ * 285,366	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	BRADLEY ALTER		ADMINISTRATION		SEE ATTACHED SCHEDULE			SALARY	$ 57,752	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 57,752		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	244,189	8	$ 750	$	40,842	$ 125	1
2	5	ELECTRIC & GAS	" " "	244,189	8	0		40,842	0	2
3	6	MAINTENANCE	" " "	244,189	8	420		40,842	70	3
4	10	NURSING/MEDICAL RECORDS	" " "	244,189	8	127,817	127,817	40,842	21,378	4
5	17	ADMIN SALARIES	" " "	244,189	8	349,136	349,136	40,842	58,395	5
6	19	PROFESSIONAL FEES	" " "	244,189	8	20,751		40,842	3,471	6
7	20	FEE, SUBSCRIPTIONS	" " "	244,189	8	285		40,842	48	7
8	21	OFFICE EXP.	" " "	244,189	8	801,665	683,000	40,842	134,083	8
9	22	EMPLOYEE BENEFITS	" " "	244,189	8	168,109		40,842	28,117	9
10	24	TRAVEL/SEMINAR	" " "	244,189	8	63,242		40,842	10,578	10
11	25	TRANSPORTATION	" " "	244,189	8	80,653		40,842	13,490	11
12	26	INSURANCE	" " "	244,189	8	23,179		40,842	3,877	12
13	30	DEPRECIATION	" " "	244,189	8	18,257		40,842	3,054	13
14	32	INTEREST	" " "	244,189	8	0		40,842	0	14
15	34	OFFICE RENT	" " "	244,189	8	48,291		40,842	8,077	15
16	35	EQUIPMENT RENTAL	" " "	244,189	8	3,606		40,842	603	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,706,161	$ 1,159,953		$ 285,366	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: GLENWOOD TERRACE LLC
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-4700
Fax Number: (847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT COSTS	1	1	$ 164,991	$	1	$ 164,991	1
2	31	AMORTIZATION		1	1	24,533		1	24,533	2
3	32	INTEREST		1	1	477,503		1	477,503	3
4	21	OFFICE EXP		1	1	2,833		1	2,833	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 669,860	$		$ 669,860	25

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	BARRY KIRSCHENBAUM	X		MORTGAGE	$48,244.00	1/1/99	$ 5,796,000	$ 5,350,513	1/1/24	8.9000	$ 477,503	1
2												2
3												3
4												4
5												5
	Working Capital											
6	BANK FINANCIAL		X	WORKING CAPITAL	DEMAND					PRIME+	15,790	6
7	INS FINANCING		X								4,523	7
8												8
9	TOTAL Facility Related				$48,244.00		$ 5,796,000	$ 5,350,513			$ 497,816	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,796,000	$ 5,350,513			$ 497,816	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 438,663	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 376,473	2
3. Under or (over) accrual (line 2 minus line 1).		$ (62,190)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 384,003	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 42,317 For 2000 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$ (42,317)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 279,496	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	392,834	8
	2000	402,704	9
	2001	430,062	10
	2002	430,062	11
	2003	376,473	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD HEALTHCARE & REHAB COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032839

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	32-10-201-009-0000	NURSING HOME	$ 376,473.08	$ 376,473.08
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 376,473.08	$ 376,473.08

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 98,010 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1999	$ 322,000	1
2					2
3	TOTALS			$ 322,000	3

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	184		1999		$ 5,474,000	$ 140,359	39	$ 140,359	$ (0)	$ 842,154	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1988	20,662	656	30	689	33	11,057	9
10	LEASEHOLD IMPROVEMENTS			1989	4,071	129	30	136	7	2,108	10
11	LEASEHOLD IMPROVEMENTS			1990	28,171	894	30	939	45	13,616	11
12	LEASEHOLD IMPROVEMENTS			1991	31,712	1,007	30	1,057	50	14,270	12
13	LEASEHOLD IMPROVEMENTS			1992	10,071	320	30	336	16	4,200	13
14	LEASEHOLD IMPROVEMENTS			1993	4,810	153	30	160	7	1,903	14
15	LEASEHOLD IMPROVEMENTS			1994	17,744	455	39	455	(0)	4,322	15
16	LIGHT FIXTURES, ROOM SIGNS, HAND RAILS			1995	6,343	163	39	163	(0)	1,764	16
17	HEATING/AIR CONDITIONING			1995	12,515	320	39	321	1	3,464	17
18	NURSING STATION			1995	10,384	266	39	266	0	2,782	18
19	SPRINKLER/LANUDRY VENTILATION REPAIR			1995	2,360	61	39	61	(0)	624	19
20	LAMPS, VIDEO CAMERA, PANIC DEVICE, WATER COOLER			1996	3,650	94	39	94	(0)	907	20
21	EXIT & OUTDOOR SIGNS			1996	4,237	109	39	109	(0)	1,027	21
22	WINDOWS, DOORS, CEILING TILES/CARPET			1996	25,090	643	39	643	0	5,918	22
23	HVAC WIRING REPAIR			1996	1,540	39	39	39	0	362	23
24	TIME CLOCKS,HEAT & COOL UNITS			1997	7,022	180	39	180	0	1,358	24
25	NURSE STATION			1997	5,615	144	39	144	(0)	1,086	25
26	FLOOR/CEILING TILES, COUNTER & CABINETS			1997	21,659	556	39	555	(1)	4,260	26
27	DOORS, LIGHTS, SIGHNS			1997	14,825	380	39	380	0	2,938	27
28	BURNERS & ELECTRICAL FOR WASHER			1997	1,964	50	39	50	0	377	28
29	SIGNS, PATIO SURFACE			1998	6,994	466	15	466	0	3,029	29
30	WINDOWS & INSTALLATION			1998	18,944	486	39	486	(0)	3,382	30
31	KITCHEN REMODEL			1998	50,500	1,295	39	1,295	(0)	9,013	31
32	ELECTRIC WORK			1998	7,545	193	39	193	0	1,263	32
33	CARPET, WALLPAPER, HANDRAIL, BUMPER GUARD			1998	79,382	2,036	39	2,035	(1)	12,742	33
34	GENERATOR			1999	56,533	1,450	39	1,450	(0)	8,641	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HEAT AND AIR CONDITIONER	1999	$ 14,673	$ 376	39	$ 376	$ 0	$ 2,084	37
38	VINYL FLOORING AND TILES	1999	5,505	141	39	141	0	770	38
39	ROOF AND TUCKPOINT	1999	59,360	1,522	39	1,522	0	8,182	39
40	AIR CONDITIONER/COMPRESSOR	2000	9,868	1,410	7	1,410	(0)	8,057	40
41	ROOF REPAIR	2000	3,750	136	27.5	136	0	652	41
42	VINYL TILE/COVE BASE	2000	19,277	701	27.5	701	(0)	3,291	42
43	ALARM WORK	2000	3,848	140	27.5	140	(0)	586	43
44	DRAPERIES	2001	1,750	64	27.5	64	(0)	248	44
45	ELECTRICAL WORK	2001	5,550	201	27.5	202	1	732	45
46	TILE	2002	13,079	476	27.5	476	(0)	1,131	46
47	TILE	2003	13,545	493	27.5	493	(0)	718	47
48	WALL AC UNITS	2003	1,246	45	27.5	45	0	66	48
49	WALL CASE FOR AC	2003	622	23	27.5	23	(0)	33	49
50	WALL CASE FOR AC	2003	631	23	27.5	23	(0)	34	50
51	WALL CASE FOR AC	2003	607	22	27.5	22	0	32	51
52	SHINGLES	2003	700	25	27.5	25	0	37	52
53	COVE BASE	2003	939	34	27.5	34	0	50	53
54	WALL AC UNITS	2003	1,223	44	27.5	44	0	64	54
55	WALL AC UNITS	2003	2,113	77	27.5	77	(0)	112	55
56	WINDOW TREATMENTS	2003	24,200	7,744	5	4,840	(2,904)	7,260	56
57	LANDSCAPING	2003	16,500	1,100	15	1,100		1,467	57
58	ELECTRICAL WORK	2004	2,400	87	27.5	87	0	87	58
59	DOOR REPLACEMENT	2004	537	10	27.5	10	(0)	10	59
60	ROOF REPAIR	2004	6,900	125	27.5	125	0	125	60
61	DINING ROOM DOOR CONTROL UNIT	2004	1,317	24	27.5	24	(0)	24	61
62	FRONT DOOR CONTROL UNIT	2004	1,318	24	27.5	24	(0)	24	62
63	COVE BASE	2004	1,087	20	27.5	20	(0)	20	63
64	RESIDENT DOORS REFINISHED/INSTALLED	2004	5,500	100	27.5	100		100	64
65	WALLPAPER REMOVAL/INSTALL	2004	11,251	90	27.5	205	115	205	65
66	KICK PLATES	2004	2,453	45	27.5	45	(0)	45	66
67	WALL AC UNITS	2004	2,291	42	27.5	42	(0)	42	67
68	WALLPAPER REMOVAL/INSTALL	2004	10,928	199	27.5	199	(0)	199	68
69									69
70	TOTAL (lines 4 thru 69)		$ 6,173,311	$ 168,467		$ 165,835	$ (2,632)	$ 995,053	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 294,651	$ 19,387	$ 43,652	$ 24,265	5-7 YEARS	$ 136,669	71
72	Current Year Purchases	24,745	412	450	38	27.5	450	72
73	Fully Depreciated Assets	161,234					161,324	73
74			27,686	27,686				74
75	TOTALS	$ 480,630	$ 47,485	$ 71,788	$ 24,303		$ 298,443	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,975,941	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 215,952	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 237,623	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 21,671	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,293,496	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 13,189 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 155,053	$		$ 155,053	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,488			1,488	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			159,589			159,589	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				64,239		64,239	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES & Other (specify): LABORATORY	39-2					19,703		19,703	13
14	TOTAL			$		$ 316,130	$ 83,942		$ 400,072	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 80,466)	600,343		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	42,976		6
7	Other Prepaid Expenses	20,476		7
8	Accounts Receivable (owners or related parties)	326,568		8
9	Other(specify): R/E TAX DEPOSIT	301,552		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,291,915	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	699,312		15
16	Equipment, at Historical Cost	480,629		16
17	Accumulated Depreciation (book methods)	(584,366)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 595,575	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,887,490	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 681,594	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,000		28
29	Short-Term Notes Payable	473,547		29
30	Accrued Salaries Payable	64,756		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,194		31
32	Accrued Real Estate Taxes(Sch.IX-B)	384,003		32
33	Accrued Interest Payable	2,026		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,630,120	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,630,120	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 257,370	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,887,490	$	48

*(See instructions.)

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 196,083	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 196,083	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	61,287	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 61,287	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 257,370	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,113,163	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,113,163	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	440,129	6
7	Oxygen	17,494	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 457,623	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 8	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,570,794	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	962,587	31
32	Health Care	1,831,305	32
33	General Administration	1,317,502	33
	B. Capital Expense		
34	Ownership	897,025	34
	C. Ancillary Expense		
35	Special Cost Centers	400,072	35
36	Provider Participation Fee	101,016	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,509,507	40
41	**Income before Income Taxes (line 30 minus line 40)****	61,287	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 61,287	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	648	648	$ 19,514	$ 30.11	1
2	Assistant Director of Nursing	4,024	4,160	97,500	23.44	2
3	Registered Nurses	7,335	7,695	210,635	27.37	3
4	Licensed Practical Nurses	17,689	18,801	398,855	21.21	4
5	Nurse Aides & Orderlies	65,417	69,452	611,698	8.81	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,973	2,261	30,861	13.65	8
9	Activity Director	834	889	12,038	13.54	9
10	Activity Assistants	11,741	13,005	117,949	9.07	10
11	Social Service Workers	2,603	2,675	41,246	15.42	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	38,868	18.69	13
14	Head Cook					14
15	Cook Helpers/Assistants	4,029	4,609	48,020	10.42	15
16	Dishwashers	15,516	16,881	123,074	7.29	16
17	Maintenance Workers	3,134	3,524	50,172	14.24	17
18	Housekeepers	15,925	17,319	153,570	8.87	18
19	Laundry	13,022	14,003	99,849	7.13	19
20	Administrator	968	1,040	31,068	29.87	20
21	Assistant Administrator	3,944	4,160	99,239	23.86	21
22	Other Administrative					22
23	Office Manager	3,944	4,160	60,647	14.58	23
24	Clerical	5,473	6,137	53,291	8.68	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,032	2,080	25,179	12.11	31
32	Other Health C: CARE PLAN COO	3,454	3,550	59,663	16.81	32
33	Other(specify) MARKETING	3,357	3,445	50,614	14.69	33
34	TOTAL (lines 1 - 33)	189,062	202,574	$ 2,433,550 *	$ 12.01	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	168	$ 6,720	1-3	35
36	Medical Director	1500/month	17,200	9-3	36
37	Medical Records Consultant	50	1,598	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant	100/month	1,215	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant	9	455	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	90	3,180	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	317	$ 30,368		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	210	$ 8,911	10-3	50
51	Licensed Practical Nurses	1,355	44,728	10-3	51
52	Nurse Aides	45	1,204	10-3	52
53	TOTAL (lines 50 - 52)	1,610	$ 54,843		53

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DIANE MIKES	ADMIN	0	$ 31,068
CELESTE PHILLIP	ASST ADMIN	0	56,150
LISA SMITH	ASST ADMIN	0	43,089
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 130,307

B. Administrative - Other

Description	Amount
CERTIFIED HEALTH MANAGEMENT	$ 61,440
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 61,440

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		93,097
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 93,097

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 114,355
Unemployment Compensation Insurance		44,245
FICA Taxes		182,759
Employee Health Insurance		99,973
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,252
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		11,214
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
MGMT CO ALLOCATION		28,117
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 481,915

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
NONE		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	17,768
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	18,512
TRUST/FRANCHISE/CONTRIB/ETC	250
LICENSES & PERMITS	2,973
DUES & SUBSCRIPTIONS	0
MGMT CO ALLOCATION	48
TRUST/FRANCHISE/CONTRIB/ETC	(250)
Less: Public Relations Expense	(0)
Non-allowable advertising	(6,756)
Yellow page advertising	(11,756)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,789

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	2,362
MGMT CO ALLOCATION	10,578
Seminar Expense	800
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13,740

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GLENWOOD HEALTHCARE & REHAB # 0032839 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **yes**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **101,016**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **no** If no, please explain. **review not yet completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees